

(c) *General certification criteria.* The Exchange may certify a health plan as a QHP in the Exchange if—

(1) The health insurance issuer provides evidence during the certification process in §155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156, as applicable; and

(2) The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, except that the Exchange must not exclude a health plan—

(i) On the basis that such plan is a fee-for-service plan;

(ii) Through the imposition of premium price controls; or

(iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

#### § 155.1010 Certification process for QHPs.

(a) *Certification procedures.* The Exchange must establish procedures for the certification of QHPs consistent with §155.1000(c).

(1) *Completion date.* The Exchange must complete the certification of the QHPs that will be offered during the open enrollment period prior to the beginning of such period, as outlined in §155.410.

(2) *Ongoing compliance.* The Exchange must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements in §155.1000(c).

(b) *Exchange recognition of plans deemed certified for participation in an Exchange.* Notwithstanding paragraph (a) of this section, an Exchange must recognize as certified QHPs:

(1) A multi-State plan certified by and under contract with the U.S. Office of Personnel Management.

(2) A CO-OP QHP as described in subpart F of part 156 and deemed as certified under §156.520(e).

#### § 155.1020 QHP issuer rate and benefit information.

(a) *Receipt and posting of rate increase justification.* The Exchange must ensure that a QHP issuer submits a justification

for a rate increase for a QHP prior to the implementation of such an increase, except for multi-State plans, for which the U.S. Office of Personnel Management will provide a process for the submission of rate increase justifications. The Exchange must ensure that the QHP issuer has prominently posted the justification on its Web site as required under §156.210. To ensure consumer transparency, the Exchange must also provide access to the justification on its Internet Web site described in §155.205(b).

(b) *Rate increase consideration.* (1) The Exchange must consider rate increases in accordance with section 1311(e)(2) of the Affordable Care Act, which includes consideration of the following:

(i) A justification for a rate increase prior to the implementation of the increase;

(ii) Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act; and

(iii) Any excess of rate growth outside the Exchange as compared to the rate of such growth inside the Exchange.

(2) This paragraph does not apply to multi-State plans for which the U.S. Office of Personnel Management will provide a process for rate increase consideration.

(c) *Benefit and rate information.* The Exchange must receive the information described in this paragraph, at least annually, from QHP issuers for each QHP in a form and manner to be specified by HHS. Information about multi-State plans may be provided in a form and manner determined by the U.S. Office of Personnel Management. The information identified in this paragraph is:

(1) Rates;

(2) Covered benefits; and

(3) Cost-sharing requirements.

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#### § 155.1040 Transparency in coverage.

(a) *General requirement.* The Exchange must collect information relating to coverage transparency as described in §156.220 of this subtitle from QHP issuers, and from multi-State plans in

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a time and manner determined by the U.S. Office of Personnel Management.

(b) *Use of plain language.* The Exchange must determine whether the information required to be submitted and made available under paragraph (a) of this section is provided in plain language.

(c) *Transparency of cost-sharing information.* The Exchange must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an individual as required by § 156.220(d) of this subtitle.

#### § 155.1045 Accreditation timeline.

The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

#### § 155.1050 Establishment of Exchange network adequacy standards.

(a) An Exchange must ensure that the provider network of each QHP meets the standards specified in § 156.230 of this subtitle, except for multi-State plans.

(b) The U.S. Office of Personnel Management will ensure compliance with the standards specified in § 156.230 of this subtitle for multi-State plans.

(c) A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under § 156.235(c) of this subtitle.

#### § 155.1055 Service area of a QHP.

The Exchange must have a process to establish or evaluate the service areas of QHPs to ensure such service areas meet the following minimum criteria:

(a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.

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(b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

#### § 155.1065 Stand-alone dental plans.

(a) *General requirements.* The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and

(3) The plan and issuer of such plan meets QHP certification standards, including § 155.1020(c), except for any certification requirement that cannot be met because the plan covers only the benefits described in paragraph (a)(2) of this section.

(b) *Offering options.* The Exchange may allow the dental plan to be offered—

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) *Sufficient capacity.* An Exchange must consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage.

(d) *QHP Certification standards.* If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

#### § 155.1075 Recertification of QHPs.

(a) *Recertification process.* Except with respect to multi-State plans and CO-OP QHPs, an Exchange must establish a process for recertification of QHPs that, at a minimum, includes a review